Clinical Utility and Global Applicability of Prolonged Grief Disorder in the ICD-11 from the Perspective of Chinese and German-Speaking Health Care Professionals

Stelzer, Eva-Maria ; Zhou, Ningning ; Merzhvynska, Mariia ; Rohner, Stefan ; Sun, Han ; Wagner, Birgit ; Maercker, Andreas ; Killikelly, Clare

Abstract: BACKGROUND: Prolonged grief disorder (PGD) is included in the ICD-11 (11th edition of the International Classification of Diseases). The new PGD criteria reflect the requirements and recommendations of the World Health Organization for improved clinical utility and international applicability. Even though the ICD classification system is globally used, no research has investigated how healthcare professionals (HP) in non-Western countries may adopt this change for their own practice. OBJECTIVE: The present study explored the extent to which the new PGD criteria were accepted and perceived to meet the standards for clinical utility and international applicability among Chinese and German-speaking HP. METHODS: Individual semistructured interviews were conducted in person, by phone, or online (e.g., via Skype), with 24 Chinese (n = 10) and German-speaking (n = 14) HP working with bereaved populations in China and Switzerland, and analyzed using a qualitative framework analysis. Questions included "what items are currently missing from the PGD criteria?". RESULTS: Across all HP, the majority supported the inclusion of PGD and were generally aligned with the current criteria. HP found that the criteria distinguished between normal and abnormal grief and considered the criteria easy to use if their modifications were considered. Merits included, among others, improved clinical decision making, research promotion, and social acknowledgment. Main concerns included misdiagnosis, pathologization, and a lack of specificity of criteria. The importance of international applicability was emphasized across Chinese and German-speaking HP. Different grief-specific symptoms were identified by German-speaking and Chinese HP. CONCLUSIONS: These findings provide evidence for the clinical utility and international applicability of ICD-11 PGD criteria among German-speaking and Chinese HP, as well as cultural similarities and differences in the barriers to implementation of these criteria.

DOI: https://doi.org/10.1159/000505074

Disorder in the ICD-11 from the Perspective of Chinese and German-Speaking Health Care Professionals. Psychopathology, 53(1):8-22.
DOI: https://doi.org/10.1159/000505074

Research Article

Psychopathology

Psychopathology
DOI: 10.1159/000505074

Received: June 12, 2019
Accepted after revision: November 26, 2019
Published online: March 6, 2020

Clinical Utility and Global Applicability of Prolonged Grief Disorder in the ICD-11 from the Perspective of Chinese and German-Speaking Health Care Professionals

Eva-Maria Stelzer[a, b] Ningning Zhou[a, c] Mariia Merzhvynska[a] Stefan Rohner[a] Han Sun[a] Birgit Wagner[d] Andreas Maercker[a] Clare Killikelly[a]

[a]Department of Psychology, University of Zurich, Zurich, Switzerland; [b]Department of Psychology, University of Arizona, Tucson, AZ, USA; [c]Faculty of Psychology, Beijing Normal University, Beijing, PR China; [d]MSB Medical School Berlin – Hochschule für Gesundheit und Medizin, Berlin, Germany

Keywords
Prolonged grief disorder · ICD-11 · Qualitative analysis · Cross-cultural research

Abstract
Background: Prolonged grief disorder (PGD) is included in the ICD-11 (11th edition of the International Classification of Diseases). The new PGD criteria reflect the requirements and recommendations of the World Health Organization for improved clinical utility and international applicability. Even though the ICD classification system is globally used, no research has investigated how healthcare professionals (HP) in non-Western countries may adopt this change for their own practice. ***Objective:*** The present study explored the extent to which the new PGD criteria were accepted and perceived to meet the standards for clinical utility and international applicability among Chinese and German-speaking HP. ***Methods:*** Individual semistructured interviews were conducted in person, by phone, or online (e.g., via Skype), with 24 Chinese ($n = 10$) and German-speaking ($n = 14$) HP working with bereaved populations in China and Switzerland, and analyzed using a qualitative framework analysis. Questions included "what items are currently missing from the PGD criteria?". ***Results:*** Across all HP, the majority supported the inclusion of PGD and were generally aligned with the current criteria. HP found that the criteria distinguished between normal and abnormal grief and considered the criteria easy to use if their modifications were considered. Merits included, among others, improved clinical decision making, research promotion, and social acknowledgment. Main concerns included misdiagnosis, pathologization, and a lack of specificity of criteria. The importance of international applicability was emphasized across Chinese and German-speaking HP. Different grief-specific symptoms were identified by German-speaking and Chinese HP. ***Conclusions:*** These findings provide evidence for the clinical utility and international applicability of ICD-11 PGD criteria among German-speaking and Chinese HP, as well as cultural similarities and differences in the barriers to implementation of these criteria.

In the history of psychiatry and clinical psychology, diagnostic classification systems such as the ICD (International Classification of Diseases) and the DSM have been cornerstones for the improvement of clinical decision making and provision of valid and accessible tools

Ningning Zhou
Faculty of Psychology, Beijing Normal University
No. 19 Xinjiekouwai St., Haidian District
Beijing 100875 (PR China)
zhouningning1990@mail.bnu.edu.cn

for clinical practice. However, in the latest revision of the ICD-11 there is a shift from further specification and refinement of diagnostic categories to the adoption of a narrative approach that seeks to place clinical expertise at the center of diagnosis [1]. The new ICD-11 diagnostic guidelines for prolonged grief disorder (PGD) were developed in line with this new remit [2].

According to the ICD-11 [3], PGD is characterized by a longing for the deceased or persistent preoccupation with the deceased, emotional pain (e.g., sadness, guilt, anger, blame, denial, and feeling that life is empty) and functional impairment. In order to meet a PGD diagnosis, the above symptoms should last for more than 6 months, and the severity and duration of grief symptoms should clearly exceed the expected social, cultural and religious norms of the individual. These new guidelines are in line with the requirements and recommendations of the WHO for improved clinical utility and international applicability [4]. In a recent opinion piece, Killikelly and Maercker [5] suggest that the new ICD-11 guidelines are concise and simple to use, as well as distinctive from other comorbid mental disorders (e.g., depression, anxiety, posttraumatic stress disorder, and adjustment disorder).

Despite this change in diagnostic systems, there is still a gap between research and clinical practice. By examining the perspectives of healthcare professionals (HP) and the public on these guidelines, we may be able to narrow this gap and better inform the direct application of these guidelines. Several researchers have explored the opinions and beliefs of HP and bereaved individuals regarding the inclusion of a disorder of grief. For example, a recent survey found that 25–43% of HP believed that PGD should be included in diagnostic systems [6, 7], and 51–75% of the public also support this inclusion [8–10]. In terms of the positive attitudes toward the inclusion, Dietl et al. [7] suggested that 46.3% of their 2,088 German-speaking HP believed that assigning a PGD diagnosis would promote a more effective treatment for affected persons. This was confirmed in other studies [6, 11]. In addition, assigning a PGD diagnosis can help to reduce the stigma and self-blame for people with severe grief [12]. At the same time, concerns were also reported. For example, 51.1% of German-speaking HP believed that the inclusion of PGD would lead to an "increase in pathologization of normal grief" and 40.7% believed that an "increase in inadequate intervention" would occur after including or assigning the PGD diagnosis [7]. Additionally, misdiagnosis of PGD was discussed frequently by clinicians and researchers [13]. Indeed, in the case-controlled field study trial, misdiagnosis of PGD by clinicians is frequent (50% of clinicians incorrectly identified "normal" grief as pathological) [14]. In terms of the content accuracy and acceptability of the ICD-11 PGD guidelines, studies demonstrated that the new PGD criteria were perceived to be moderate to quite accurate and could distinguish between prolonged grief and normal grief as well as other near neighbor disorders [7, 14]. Some researchers also examined HP perspectives about time and cultural expectation criteria and found that only 11% of HP supported a period of 6 months as the minimum duration before grief can be considered a disorder. Fifty-seven percent of HP proposed that it would be difficult in practice to assess the cultural expectation criteria [7].

Although the above literature examined the clinical utility and global applicability of the PGD diagnosis, some research gaps still exist. First, whether or not the specific features of the new ICD-11 PGD guidelines are appropriate has yet to be examined. For example, it remains unknown whether there are missing or redundant features in the present guidelines. Second, the global applicability of the new ICD-11 PGD diagnosis has scarcely been studied. To our knowledge, only 1 study reported that 69% of HP believed that "the diagnosis of PGD is difficult to apply across cultures," while this study did not report the kind of difficulties and how to overcome them [7]. Only by using a qualitative research design can such questions be answered directly and in depth. Moreover, no research has investigated the perspectives of HP from non-Western countries on inclusion of the new PGD criteria or the potential cross-cultural differences in the perspectives of HP between Global North and Eastern countries. A cross-cultural study is necessary in order to investigate the global applicability of the ICD-11 PGD guidelines.

Considering the above gaps in the previous literature, the aim of this study was to directly elicit and explore practitioners' views about the clinical utility and global applicability of the new ICD-11 PGD guidelines by using a cross-cultural qualitative design. It was anticipated that the practitioners' opinions would have implications for the application of these new ICD-11 guidelines in clinical practice and in future research.

Methods

Design

A qualitative design was used to explore HP perspectives on the new ICD-11 PGD features. Data were collected via semistructured interviews which allowed for flexible data collection, and elicited open responses, while ensuring that relevant topics were covered across all interviews [15, 16].

Setting and Participants

Data were collected from German-speaking and Chinese HP. A number of "key informants" [17] from universities, hospitals, psychological counseling centers, and social service organizations were purposively sampled to participate in the present study. Eligible key informants had expertise in working with bereaved individuals or conducting research in the area of bereavement and grief. To recruit participants, we emailed institutions and organizations who work with dying and bereaved individuals. Maximum variation sampling [18] was employed to obtain a diverse sample of key informants with a wide range of views and perspectives. Based on guidelines for key informant interviews [19, 20] we sought experts with intimate knowledge of the subject of grief from a variety of professional backgrounds relevant to mental health. Ultimately, 14 Swiss HP and 10 Chinese HP participated in a semistructured interview. Interviews were conducted in person, by phone, or online (e.g., via Skype) between August and November 2018 with trained master-in-psychology students. Depending on the participants' availability and preferences, in-person interviews were conducted at our research unit or at the participants' office. Interviews lasted approximately 1.5–2 h (German-speaking sample: mean duration = 2.04 h, SD = 0.2; Chinese sample: mean duration = 1.61 h, SD = 0.32). Interviews were conducted in German for the Swiss part and in Mandarin Chinese for the Chinese part. Each interview was audio recorded and transcribed.

A semistructured interview guide was developed by the researchers and validated by an expert in clinical psychology and bereavement (B.W.). The guide was divided into questions on the clinical utility of the ICD-11 PGD criteria, suggestions for adaptation, development of a questionnaire, and explanatory models of PGD. Prior to the interview, the ICD-11 PGD criteria were sent to the HP via email in order to make sure they were familiar with these newly proposed criteria. The present paper only focuses on clinical utility and suggestions for adaptation. HP were asked open-ended questions to describe in detail their perspectives, comments, feelings, and reactions toward the newly proposed criteria, allowing for probing of further information and clarification where appropriate. Examples of questions are "what is the merit/demerit of introducing a new disorder to the German-speaking/Chinese clinical culture?" or "how do you think HP will react to this change in the ICD-11?" (online suppl. Table 1; see www.karger.com/doi/10.1159/000505074 for all online suppl. material).

Ethical approval was provided by the Faculty of Arts and Social Sciences research ethics committee of the University of Zurich.

Data Analysis

Interviews were transcribed verbatim and data were analyzed using thematic analysis and the framework method [20–22] which allows themes to be developed both deductively from research questions and inductively from participant narratives [23]. All of the data were coded and analyzed according to the 5 stages of thematic analysis which involves: (1) familiarization with the data (listening to interviews and reading through printed transcripts), (2) identification of a coding framework (using the interview questions as a deductive coding structure and identifying codes within each question), (3) generation of subthemes based on the initial coding framework (applying the codes and developing new codes across the entire dataset), (4) review of the themes within the research team to develop a consensus coding framework, and (5) indexing of all transcripts by systematically applying the resulting thematic framework across all interviews. We used the framework method to systemically organize the data. This is done through charting of data into a matrix of rows (cases) and columns (codes) to summarize the data. This allows for analysis of key themes across the whole dataset and comparing and contrasting across participants. It is also the recommended method for use with multiple researchers [22]. Regular meetings between the researchers ensured a thorough data analysis. Any disagreements were resolved by consultation with C.K. The main qualitative analysis was conducted by E.S. for the German data and by N.Z. for the Chinese data. To ensure the quality of the data analysis and good intercoder reliability the data were coded by 2 additional coders for the German data (M.M. and S.R.) and 1 additional coder for the Chinese data (H.S.). The qualitative software Maxqda 18.1.1 was used for coding.

Participant Characteristics

Table 1 presents an overview of the demographic and professional information of the study participants.

Table 1. Demographic and professional information of the study participants and current use of diagnostic classification systems

	German-speaking sample (n = 14)	Chinese sample (n = 10)
Female gender	12 (85.7)	8 (80.0)
Age, years	50.31±9.86	40.60±13.60
Profession		
Psychotherapist[1]	3 (21.4)	1 (10.0)
Social worker	1 (7.1)	2 (20.0)
Grief counselor	3 (21.4)	
Psychological counselor	2 (14.3)	
Pastor, theologian	2 (14.3)	
Palliative care nurse	1 (7.1)	
Psychiatrist		1 (10.0)
Clinical researcher	2 (14.3)	6 (60.0)
Professional experience working with bereaved persons, years	13.27±8.59	11.30±9.79
Use of a diagnostic classification system[2]		
ICD or DSM	4 (28.6)	7 (70.0)
Other[3]	3 (21.4)	1 (10.0)[4]
None	7 (50.0)	3 (30.0)

Values are presented as means ± SD or numbers (%). [1] With specialization in cognitive behavioral therapy, psychoanalysis, and systemic therapy. [2] The number exceeds the total number since 1 Chinese HP uses both the DSM and another system. [3] Country-specific system such as the Chinese Classification of Mental Disorders (CCMD). [4] One Chinese HP (KI 002C) used the DSM in clinical practice and the Inventory of Complicated Grief in research.

Results

Our analysis revealed a wide variety of discrete themes and subthemes. For clarity and in line with the mission of the WHO ICD-11, we have categorized the interview questions, emerging themes, and thematic content into 2 overarching results sections: (1) clinical utility, and (2) global applicability.

Clinical Utility

Relevant themes and thematic content were categorized under the corresponding domains of clinical utility: "accuracy of diagnosis" and "ease of use" (online suppl. Table 1).

Accuracy of Diagnostic Guidelines

Three interview questions and the resultant thematic content explored the topic of accuracy of diagnostic guidelines across the Swiss and Chinese interviews; the diagnostic guidelines (1) reflect clinical cases, (2) differentiate between abnormal and normal grief, and (3) differentiate from other mental disorders.

According to a majority of German-speaking HP, the current PGD criteria reflect clinical cases. Not only do the newly proposed ICD-11 criteria reflect symptoms commonly seen by HP in patients who experience difficulties adjusting to the loss, but these are also the symptoms typically explored by HP during a clinical intake. Ten out of 14 German-speaking HP and 6 out of 7 Chinese-speaking HP (3 Chinese-speaking HP indicated that they did not use a diagnostic system) believed that the ICD-11 PGD criteria enable clinicians to distinguish between normal and prolonged grief. HP agreed that PGD can distinguish sub(clinical) and clinical grief based on grief duration (i.e., time criterion), symptom intensity, associated functional impairment, and contextual factors (e.g., death circumstances) as well as the presence of the 2 hallmark symptoms (i.e., yearning and preoccupation). In addition, the majority of HP agreed that the new criteria are grief specific and can accurately differentiate PGD from other mental disorders (e.g., depression, posttraumatic stress disorder or adjustment disorder) based on its two hallmark symptoms. Three Chinese-speaking HP mentioned that there is a large overlap between PGD and both depression and PTSD regarding the accessory symptoms, and one German-speaking HP highlighted that a distinction from other mental health disorders is not possible if HP solely focus on the accessory symptoms (i.e., emotional distress).

Nevertheless, many HP discussed that the current symptoms can appear in both normal and prolonged grief trajectories. According to German speaking HP the current criteria reflect cognitions, emotions, and behavior commonly endorsed as part of a normal grief response which would not distinguish the cases from PGD cases if the length and intensity of the symptoms are not considered. For instance, HP discussed that PGD symptoms such as difficulty accepting the loss or emotional numbness are commonly experienced in the aftermath, not just by patients with PGD. Both Swiss and Chinese HP mentioned that the accuracy of the diagnostic criteria could be increased by adding culturally specific symptoms (for a more detailed discussion regarding specific criteria, see Global Applicability). For example, Chinese HP suggested adding features that reflect the Chinese cultural context such as keeping the belongings of the deceased, depressive feelings, problems sleeping, and other physical reactions. One Swiss HP suggested greater specification of criteria (e.g., frequency and intensity of symptoms) and inclusion of differential exclusion criteria (similar to the ones listed in the ICD-10 for certain mental health disorders) to improve clinical accuracy and differential diagnoses from disorders such as depression, PTSD, or adjustment disorder.

Ease of Use and Implementation

Chinese- and German-speaking HP explored the topic of ease of use and implementation: (1) merits and demerits of the new criteria, (2) future use of diagnostic criteria, and (3) barriers of implementation

German-speaking and Chinese HP discussed a variety of merits and demerits of introducing a grief disorder into the ICD-11. Themes that emerged included: clinical decision making for HP, a sense of acknowledgment for bereaved patients, society in general as well as pathologizing normal grief, misdiagnosis by unexperienced HP, stigmatization, and secondary gains.

Merits for HP: Clinical Decision Making. Across both German-speaking and Chinese HP the most frequently discussed merit included the promotion of clinical decision making as it allows HP to correctly identify and diagnose patients suffering from grief complications ("finally gives clinical cases a name") and to distinguish between related or comorbid mental disorders. Related to the correct diagnosis is the HP perception that new criteria will improve treatment for patients. According to HP, a new disorder would help the HP to choose the appropriate interventions for bereaved people while avoiding incorrect therapeutic interventions such as the use of anti-

depressant medication as a first line of treatment. HP also expressed the hope that this new diagnostic entity will promote the development of specific interventions and potentially even preventative approaches ("similar to the development for PTSD"), as well as facilitate communication among HP. One Chinese HP mentioned that the new criteria can help to assess the effectiveness of government-sponsored treatment services. Chinese HP further identified that a PGD diagnosis could improve the therapeutic skills and grief-related expertise of HP.

Merits for Patients: Sense of Acknowledgment. Chinese and German-speaking HP further highlighted that an official diagnosis of PGD can create a sense of acknowledgment of patients' experience that their symptoms are shared by others and warrant assessment and further psychological services. According to Chinese HP, social acknowledgment may promote social support from HP and social networks. One German-speaking HP suggested that this diagnosis may promote a sense of confidence and security among patients, confirming that HP are familiar with this construct and can offer evidence-based treatment. This sense of social acknowledgment was extended to the general public, with HP discussing that PGD can create awareness and acceptance of different grief trajectories among the general public, medical staff, and politicians (e.g., "oftentimes, family or friends vanish from HP radar upon a patient's death"). Additionally, Chinese HP discussed that PGD allows bereaved people to learn more about grief and gain an awareness of whether their grief is problematic or not.

Merits for Society. German-speaking HP reported that a formal diagnosis would assist with insurance claims, thereby avoiding intentional misdiagnoses (e.g., depression or adjustment disorder) which were previously necessary to charge insurance companies for treatment. One Chinese social worker mentioned that the new criteria could help to assess the effectiveness of government-sponsored treatment services.

Demerits: Pathologizing Normal Grief. The most common demerit mentioned by both Chinese and German-speaking HP involves fear of pathologizing a normal process ("not that grief is pathological per se, but can result in pathological responses"), and to arbitrarily create a binary state ("if you grieve, you are considered sick; if not, then you are healthy"). According to one German-speaking HP, grief should not be assigned a diagnostic label as it removes the individuality from the grieving process. A few HP stated criteria and HP-specific barriers such as vague and unspecific criteria (e.g., the number of accessory symptoms is missing)

Demerits: Misdiagnosis by Unexperienced HP. German-speaking HP feared that inexperienced colleagues in particular may then convey the erroneous message that patients should, if possible, not grieve or, if they grieve, they should seek professional help. Misdiagnoses were discussed as more likely when HP lack experience and skills working with bereaved persons, which is common as the medical system in Germany lacks specific grief training for HP, even in the psychosocial sector. Both German-speaking and Chinese HP discussed the danger of premature or wrong diagnoses without a comprehensive clinical assessment (e.g., rushing through the diagnosis or focusing on extraordinary death circumstances such as suicide, or unfamiliarity with a patient's cultural background). Two German-speaking HP found the current PGD criteria to be misleading and vague, thereby heightening the risk of misdiagnosis.

Demerits: Stigmatization. Similar to other psychiatric disorders, both German-speaking and Chinese HP further cautioned that PGD could lead to stigmatizing reactions from others ("you can't deal with it"). Some HP mentioned that PGD may promote self-stigma, with bereaved individuals labeling themselves as "abnormal" or "pathological" once diagnosed with PGD. One Chinese HP even mentioned that some PGD patients might despair because they have such a mental disorder (e.g., "some people who are diagnosed as PGD may think they are mad and they can't be treated for the whole life"). One Chinese HP also mentioned that some people may suppress their grief reactions after 6 months to avoid the PGD label.

Demerits: Secondary Gains. Interestingly, one Chinese HP discussed the potential secondary gains for bereaved individuals that result from receiving a PGD diagnosis ("if they get more attention because of the disorder, they may not let themselves get better unconsciously").

Future Use of the New Diagnostic Criteria. Three out of 7 German-speaking HP who use official classification systems would use the current criteria in their clinical practice. Even HP who do not use official classification systems identified benefits of the new criteria for their own work and would utilize the criteria in their own practice. One HP would use the criteria as a framework when reflecting on clinical sessions and writing therapy notes, or to plan upcoming sessions. Another HP stated that she would review her current idiosyncratic system based on the PGD criteria.

Among the 7 Chinese HP who use official classification systems, 4 would use the current criteria in their clinical practice but only on the premise of having a good as-

sessment tool and the existing criteria being modified considering cultural factors. Two would not use the new criteria to make a diagnosis as the ICD-11 has not been translated into Chinese or they cautioned that they have no qualification to make such a diagnosis. Among the 3 Chinese HP who do not use any official classification system, 2 refrained from its use as they are opposed to "judging or labeling" individuals or due to the fact that there was no PGD previously.

Barriers for Implementation. Compared to the German-speaking HP, more barriers were put forward by the Chinese HP. Some demerits mentioned above may be barriers of implementation, such as misdiagnosis and worry about stigmatizing or labelling the bereaved. Despite these, some other barriers were discussed. First, Chinese HP discussed that prolonged grief is considered a nonpsychological problem in China and thus bereaved individuals do not want to pay for these services. Second, 3 HP mentioned that death is a taboo topic, with some counselors or therapists not being willing to target death and loss during their services. Instead, HP tend to give other diagnoses or only focus on emotions or other aspects rather than death-related events in order to avoid hurting patients. Third, 4 HP expressed worry about the diagnosis and postdiagnosis issues. For example, some professions reject giving a diagnosis or label per se and instead focus on conducting the treatment instead of making a diagnosis. Other HP mentioned clients' worries of lacking an appropriate therapeutic regimen. Only 1 HP stated that there was no difficulty using the new criteria – it was very straightforward and easy.

Global Applicability

The following themes of communication and cultural difference in specific features are categorized under the overarching section of themes and thematic content corresponding to global applicability.

Communication

Subthemes emerged under the main theme of communication for German and Chinese speaking HPs, including: (1) the relevance of the cultural caveat, (2) a better understanding of the patients, and (3) barriers for implementation.

Relevance of the Cultural Caveat

All German-speaking and Chinese HP considered the cultural caveat as crucial for valid and reliable clinical decision making. According to German-speaking HP, culture-sensitive assessment does justice to their increasingly diverse patient groups and creates an awareness that different ways of grieving are possible. Most importantly, HP discussed that the consideration of grief-specific sociocultural norms can prevent a premature or false diagnosis. They gave various examples of how a lack of cultural sensitivity can lead to a wrong diagnosis. For instance, one HP discussed Buddhist rituals (e.g., cooking for the deceased) endorsed by her patient. Initially, the HP considered this behavior as an indicator of preoccupation until she explored the patient's religious background.

Better Understanding

German-speaking and Chinese HP unanimously highlighted the benefit of gaining a better understanding of the patient in the context of his or her culture. For instance, one Chinese HP pointed out that the culture criterion can remind HP to consider the broad environment in which a person lives. German HP perceived the cultural caveat as an opportunity to gain a more holistic understanding of the patient and his or her symptoms and to learn more about his or her culture.

Barriers to Implementation

German-speaking and Chinese HP had mixed feelings about whether it would be difficult to assign a diagnosis to somebody from a different culture. German-speaking and Chinese HP find it very difficult and potentially even dangerous if HP are not familiar with a patient's culture or its rituals (e.g., refugees), emphasizing that valid clinical decision making depends on the expertise and skills of HP. To ensure a culturally sensitive diagnosis, HP discussed the need to be familiar with their patients' culture. One Chinese HP mentioned that the cultural expectation criterion is difficult to answer, as Chinese and Western people have a different understanding about what is normal and abnormal (e.g., the time criterion may be influenced by the cultural background). According to HP, this poses a big challenge because grief-specific cultural norms are often unclear and underresearched. In addition, there may be more interindividual variability within a cultural context, emphasizing the importance of exploring important sociocultural norms and rituals together with their patients. Other HP highlighted the need to learn more about sociocultural norms from other professions (e.g., priests) who are well versed in working with people from different cultures. HP also cautioned that culturally sensitive diagnoses are time consuming as relevant informa-

tion needs to be gathered first. Other HP found it less challenging given their experience working with individuals from other cultures. One German-speaking HP anticipated no additional difficulties as only those patients who are suffering seek help, irrespectively of their cultural background. Chinese HP further cautioned that it is unrealistic to capture cultural caveats via one feature. In addition, HP discussed that HP understanding of their own culture will influence their clinical decision making. Despite this, 5 Chinese HP suggested that a culture-sensitive diagnosis is feasible when adding examples about social expectations to the current criteria or developing a measure to assess social expectations.

Cultural Differences in Specific Features

Six themes were formulated from interview questions related to cultural differences in specific features. These are grouped into feature specific feedback and recommendations (for the 12 PGD symptoms as well as the duration and functional impairment criteria) including: (1) a lack of context, (2) culture-specific modifications (Chinese only), (3) time criterion, (4) specification of the number of accessory symptoms, (5) deletion of features, and (6) missing features. Here HP provided specific recommendations and suggestions for why and how they would improve or change specific features in the ICD-11 guidelines.

Lack of Context

The main critique involved a lack of context across both German-speaking and Chinese HP. This was noted for various symptoms. For instance, HP suggested an extension to include preoccupation with circumstances of death beyond preoccupation with the deceased. Chinese HP also discussed the too general, unclear meaning and content of preoccupation. For various features such as blame or anger, German-speaking HP suggested specifying the target of these emotions, cognitions, or behaviors (self, other, God, fate, etc.), which was also mentioned by Chinese HP. The lack of context was also discussed for the symptom reflecting difficulty in engaging with social or other activities. Here, HPs distinguished between the difficulty to participate in social activities due to lost access or the inability to socialize. Further extensions were suggested for the functional impairment feature to also include daily activities such as taking care of children, cooking, and doing chores. Two Chinese HP suggested that this feature is too vague or unspecific, hoping for clarification regarding the type of functional impairment and examples.

Culturally Specific Modifications

For the Chinese HP, there were also some culturally specific modifications. For example, Chinese HP found significant overlap among features, such as denial, blame, and anger. Chinese HP suggested rephrasing some features in order to make them more easily understandable by Chinese people. Culturally specific modifications were further suggested for loss of a part of oneself, and acceptance. According to Chinese HP, these reactions are part of a normal grief response in China and will not help to discriminate between prolonged and nonprolonged cases and thus should be deleted.

Time Criterion

The time criterion was heavily debated; 5 German-speaking HP thought that 6 months is appropriate, whereas most HP considered 6–12 months as appropriate given their clinical experience. Five out of 10 Chinese participants considered the 6-month time criterion appropriate, as this was verified by previous research and consistent with their clinical practice. The other 5 Chinese HP said that 6 months is too short, especially for bereaved parents or widow(er)s. One Chinese HP discussed that there may be a longer grief period for Chinese people, as the Chinese culture encourages a long mourning period. Another 4 Chinese HP suggested 1 year as the time criterion given that 1 year is a cycle according to Chinese rituals.

Specification of the Number of Accessory Symptoms

Both German-speaking and Chinese HP highlighted the need to specify the number of accessory symptoms, with HP suggesting at least 3 or 5 accessory features. According to HP, too many individuals would qualify for a diagnosis using the present criteria.

Deletion of Features

Five German-speaking HP suggested cutting "sadness" due to a low discriminant validity ("experienced by everybody after loss"). One Chinese HP discussed that anger typically lasts for only a very short time and is not common among bereaved people and thus should be deleted. As mentioned previously, Chinese HP also suggested deletion of the features "part of self lost" and "difficulty accepting the loss" as they reflect a normal grief response in China.

Missing Features

Features considered to be important by both German-speaking and Chinese HP but currently not listed as part of the ICD-11 PGD criteria include somatic/physical

symptoms (e.g., constant crying, sleep problems, and trouble focusing), a state of dissociation or paralysis, and loss of faith in one's world (shattered assumptions). Additional features mentioned by both German-speaking and Chinese HP which represent facets of the existing PGD criteria include the inability or resistance to bond with others/develop or maintain satisfying relationships (as part of functional impairment), behavioral grief indices (e.g., looking for the deceased as a facet of preoccupation), and being "stuck in grief." Four German-speaking HP used stuck in grief (i.e., *in Trauer stecken bleiben*) to describe a chronic state of grief with the same feelings as on day 1 rather than experience waves of grief ("grief without breaks"). Patients stuck in grief typically live in the past rather than the present and have difficulty letting go of the deceased or the circumstances of death.

Additional features listed for inclusion by German-speaking HP include drastic behavior changes, lethargy/lack of energy or drive, despair or meaninglessness, regret, emptiness, and the wish to be reunited with the deceased (including suicidal ideation). Furthermore, German-speaking HP suggested inclusion of features that represent facets of existing PGD criteria including a physical desire for the deceased (e.g., seeking a hug from the deceased as a facet of yearning), not "finding back into a rhythm," and sensing no control over one's life (as facets of functional impairment), as well as hate (as a facet of anger).

Chinese-speaking HP suggested addition of the following features: helplessness, anxiety, and depressive symptoms. Additional features mentioned by Chinese HP which represent facets of the existing PGD criteria include features about "separation distress or unstoppable attachment," "thinking of the lost relationship," and "being balled up or in a state of numbness (懵逼)." Four Chinese HP said there were no missing features.

Discussion

The present study explored whether the newly proposed ICD-11 PGD criteria meet the standards for clinical utility and international applicability from the perspective of 24 Chinese and German-speaking HP. Analyses of semistructured interviews suggest that, across cultural groups and professions, HP were, in general, aligned with the current PGD criteria, found them easy to use if modifications were implemented, and emphasized the importance of international applicability. However, important barriers to their use and implementation were identified. Chinese and German-speaking HP differed in terms of the types of barriers identified and culturally specific recommendations for improvement of the criteria. Discussions of the merits and demerits highlight culture-specific hopes and challenges associated with the implementation of the current ICD-11 PGD criteria.

Clinical Utility

According to both Chinese and German-speaking HP, the current PGD criteria represent accurate and easy-to-use diagnostic guidelines. With regard to the accuracy of PGD criteria, HP highlighted that guidelines reflect clinical cases, differentiate between abnormal and normal grief, and differentiate PGD from other mental disorders. Similar support for clinical utility was reported in a survey of German HP who on average described PGD criteria as moderate to quite accurate [7]. Further evidence for clinical utility comes from HP who indicated that they would use the new ICD-11 PGD criteria in their clinical practice despite their concerns and suggestions. In a previous study, which examined mental healthcare providers' views of a precursor version of PGD, less than half of the sample indicated that they would use the criteria if available [6]. In our sample, more than half of the sample indicated that they endorsed the acceptability for the ICD-11 PGD criteria.

A Four-Level Analysis of the Merits and Demerits of the New ICD-11 PGD Criteria

The merits and demerits/barriers of introducing this new disorder comprised different levels of influence including the individual level of HP or patients and the wider level of influence of culture/society, as well as factors related to the operationalization of the new criteria (criterion- or ICD-11-specific) barriers.

Merits

The most prominent merit included improved clinical decision making such as correct diagnosis and differential diagnosis from comorbid and related disorders. In addition, HP anticipated benefits regarding research, treatment planning, therapeutic interventions, and facilitation of communication among HP. Chinese HP further discussed that this new diagnosis may promote HP familiarity and expertise in working with bereaved persons. These merits corroborate the existing literature on Western HP perceived merits of introducing a diagnostic category for pathological grief [6, 11]. A core aim of the new

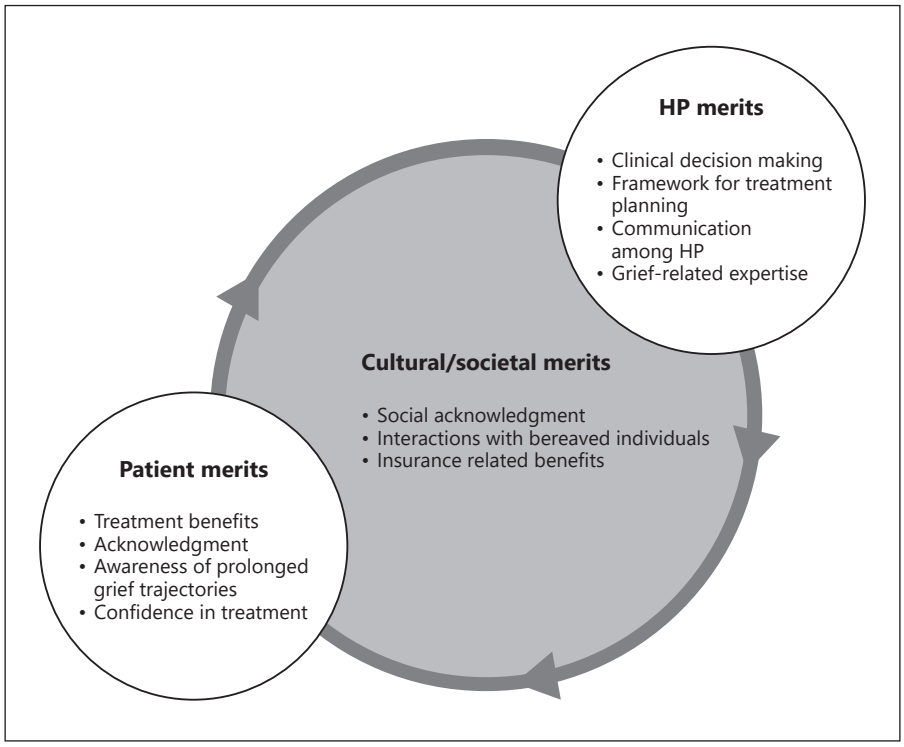

Fig. 1. Three levels of merits (cultural/societal, patient, and HP barriers).

ICD-11 revision was to ensure that the new classification guidelines were as useful as possible for clinicians. As predicted in the case-controlled field study [14], the new definition of grief was found to be clinically useful and helped clinicians to differentiate between normal and disordered grief, as well as disorder differentiation.

Along with clinical utility, a welcome finding was the support for increased discourse and awareness of disordered grief. A heightened sense of acknowledgment and a greater awareness that grief responses can go awry and professional help may be warranted were further discussed. HP also expected that this new diagnosis will give patients a sense of security and confidence that HP are trained and knowledgeable in this construct and their future care, which will likely have a positive impact on health care utilization. Currently, there are gaps in health care utilization among bereaved individuals in both China and the Global North [24] despite individuals' self-reported need for psychological care. For instance, less than a fourth of Chinese bereaved parents who lost their only child sought help from HP and less than a third of those receiving care found services to be helpful (unpubl. data). Given these numbers it is not surprising that HP hope that the new PGD criteria will stimulate a new wave of awareness, research, and grief expertise.

Many of the patient-specific merits can be extended to society in general. For instance, the hope of HP that PGD will promote patients' sense of acknowledgment was extended to the society, with HP hoping that the lay public will gain an awareness of different grief patterns. Such an increased acknowledgment of grief as a mental disorder has been discussed as promoting patients' social disclosure and their help-seeking behavior [8] while reducing stigma and self-blame [12]. Increased social acknowledgment may then lead to secondary benefits for patients such as increased levels of support towards the bereaved as discussed by the Chinese HP in our sample. For instance, more than 90% of a bereaved sample in the USA reported that they would be relieved to know that a diagnosis of disordered grief was a valid disorder, and 100% reported that they would be interested in receiving treatment for it [12].

As illustrated in Figure 1, all of these aspects are dynamic in nature with reciprocal impact. For instance, HP will benefit from the new criteria through improved clinical decision making and assessment, patients will benefit by receiving adequate and evidence-based health care, and the general public will develop a heightened sense of awareness. This increased awareness in turn likely will affect the (remove own) awareness of patients and HP regarding grief trajectories, and the care sought and offered.

Barriers to Implementation and Demerits

Barriers to implementation included barriers related to acceptability or use by HP, operational (criterion- or ICD-11-specific) issues, patients, and the stigma of PGD, as well as permeating themes related to barriers influenced by culture/society.

HP discussed specific barriers in terms of valid and reliable clinical decision making such as a lack of diagnostic experience, inexperience in use of classification systems, and a reluctance to utilize categorical classification systems. German-speaking HP further cautioned against clinical decision making by unexperienced HP who are not familiar with working with bereaved populations, with HP advocating for grief-specific continuing education programs for general physicians and psychologists or psychotherapists. A recent review underscores the lack of professional grief-specific knowledge and skills among HP and their wish for pre- and postgraduate training in bereavement in general and bereavement-related mental health conditions in particular [25]. If implemented, such trainings for HP can lead to improvements in bereavement care [26].

Related to these concerns from HPs, operational barriers which prevent Chinese HP from using the new ICD-11 PGD criteria included the lack of validated assessment tools in Chinese as well as the lack of a Chinese version of the ICD-11. In addition, both Chinese and German-speaking HP scrutinized the lack of specificity in the current diagnostic criteria and made suggestions to increase their accuracy and international applicability and to avoid misdiagnosis (see clinical implications). The concern for misdiagnosis is prevalent among clinicians and researchers [13] and appears justified given the frequent misdiagnosis of PGD by clinicians in a case study [14] and differences in prevalence rates between ICD-11 PGD and DSM-5 PCBD criteria [27].

Patient-specific barriers comprised HP concerns that this new diagnosis would promote stigma. Self-stigma and fear of discrimination was heavily discussed among Chinese and German HP. Interestingly, several German-speaking HP found a PGD diagnosis less stigmatizing than other related disorders (e.g., anxiety disorders) despite evidence suggesting that a PGD diagnosis promotes public stigma in the Global North [28]. Additional barriers discussed by Chinese HP include a reluctance to pay for and thus seek psychological bereavement services among Chinese bereaved individuals given patients' concerns regarding appropriate treatment interventions and the common perception that prolonged grief constitutes a physical, not a psychological, problem (see also societal barriers). This view is common among the Chinese (remove lay) public. In general, mental health knowledge is relatively poor among the general public in China, with individuals perceiving mental health disorders as biologically based or personal problems [10, 29]. Such beliefs hamper treatment seeking and the development of evidence-based treatments. Indeed, fear of stigma was also heavily discussed as a societal barrier. Chinese bereaved commonly experience stigma [30, 31] given societal pressures and stereotypes about mental health [29]. For instance, a common lay person belief is that people with mental disorders are dangerous or disruptive [32]. Stigma is further promoted by the dominant Chinese view that death is a taboo, which restricts support resources from HP and the general public. In Chinese culture, death marks the end of one's life and talking about this is avoided in order to avoid superstitious beliefs about fate [33]. This death-denying view in turn impacts the general Chinese public as well as Chinese HP when facing death in their personal or professional lives, leading to feelings of heightened psychological distress as well as uneasiness communicating death- or grief-related fears [33]. Figure 2 depicts the far-reaching consequences of societal norms and beliefs impacting on HP and patients, as well as logistical or operational barriers. For instance, the cultural belief that prolonged grief is a physical rather than psychological problem likely influences patients' help seeking behavior and social support offerings by others. Underutilization of health services in turn affects HP familiarity with and exposure to grief-related phenomena and decreases the awareness of grief trajectories in the general public, resulting in a vicious cycle characterized by inappropriate health care, underutilization, and stigma.

On a societal level, many HP also feared that a diagnosis of PGD would pathologize and medicalize a normal grief response. HP strongly emphasized their belief that grief is a normal response to major life stressors and shared their concerns that this new diagnosis may have a negative impact on HP and the lay public's' view of normality and abnormality. This concern confirms previously reported fears that PGD may reflect a current trend to pathologize normal human responses [6], which is also reflected in agreement rates whether grief should be considered a mental health disorder. In 2 samples of HP from the Global North, only 25–43% of HP believed that PGD should be included in diagnostic manuals [6, 7]. Among lay individuals, support for the inclusion of pathological grief in diagnostic classification systems was higher, rang-

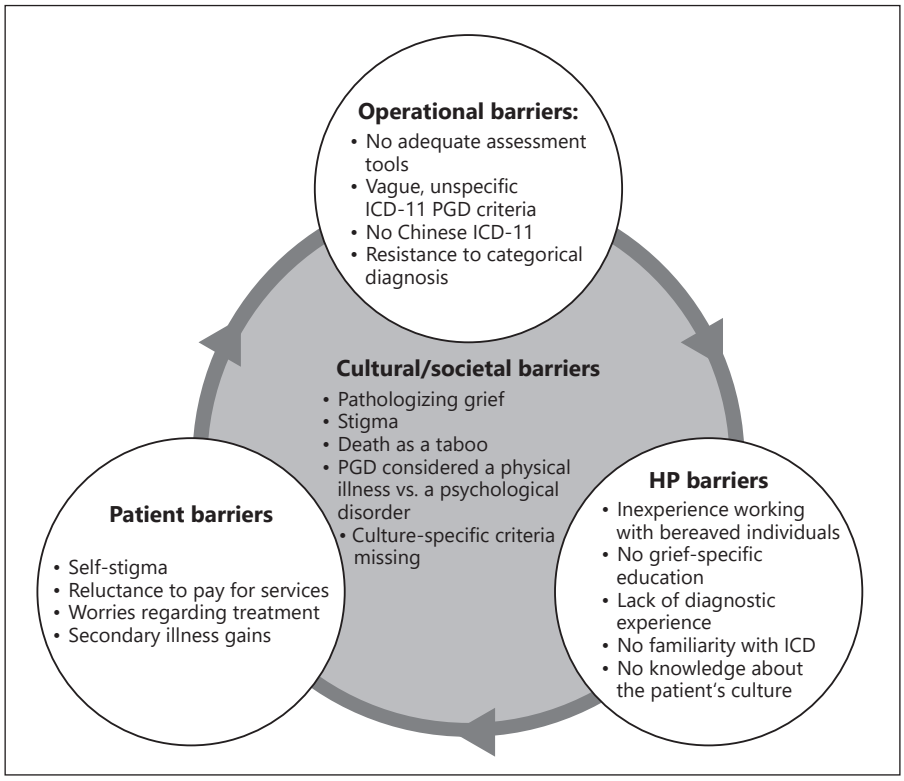

Fig. 2. Four levels of barriers (cultural/societal, operational, patient and HP).

ing from 51 [8] to 74.7% [9] in the Global North compared to 56.5% among Chinese [10].

Many of the barriers listed above often reflect both individual level as well as cultural-societal level barriers which prevent the implementation of ICD-11 criteria.

Global Applicability

One major change in the ICD-11 includes the recognition of culture-related influences on psychopathology [1]. As such, a diagnosis of PGD can only be ascertained if the symptoms violate sociocultural norms [5].

Communication

Across German-speaking and Chinese HP, the aim to enable a culture-sensitive diagnosis was unanimously confirmed to be important in order to meet the needs of increasingly diverse patient populations and to avoid misdiagnosis. The cultural caveat added to the new ICD-11 PGD criteria was therefore positively perceived by both Chinese and German-speaking HP. Despite this positive perception, HP were concerned regarding the implementation of the cultural caveat feature, for example, if HP are not familiar with a patient's culture, specific norms are unclear, or HP are pressed for time. In a quantitative study of German HP, more than half of the participants found it difficult to apply a diagnosis of PGD across cultures and assess to what extent patients' grief reactions deviate from sociocultural norms [7]. The qualitative nature of our study allowed us to explore HP recommendations to overcome the practical difficulties associated with the culture feature (see clinical implications).

Universality of Criteria

Although HP found that the ICD-11 PGD criteria reflect cases from their clinical practice, they suggested cutting, modifying, or adding missing features to improve clinical accuracy, increase comprehension, improve discriminant validity, and reflect culturally specific features. For example, German-speaking HP suggested the deletion of "sadness" while Chinese HP suggested the deletion of "loss of a part of one's self," 2 criteria with an assumed low discriminative power in the respective cultural contexts. In addition, HP expressed the wish to specify current criteria by adding relevant examples (e.g., examples of functional impairment such as the inability to do

Table 2. Feature-specific ICD-11 PGD criteria recommendations from German-speaking and Swiss HP

ICD-11 PGD criteria		German-speaking sample recommendations	Chinese sample recommendations
Event	Person experienced the death of someone close at least 6 months previously		
A. At least 1 of the following:	1. Persistent and pervasive longing for the deceased or 2. Persistent and pervasive preoccupation with the deceased	Considered very important Suggestions for features to be added or modified: – Physical desire for the deceased – Looking for the deceased – Preoccupation with the circumstances of death and/or the deceased	Important Too general for the "preoccupation" feature Suggestions for features to be added or modified: – Separation distress or un-ceased attachment – Looking for the deceased – Thinking of the past relationship
B. Some of the accessory symptoms	Accompanied by intense emotional pain, e.g.: 1. sadness, 2. guilt, 3. anger, 4. denial, 5. blame, 6. difficulty accepting the death, 7. feeling one has lost a part of one's self, 8. inability to experience a positive mood, 9. emotional numbness, and 10. difficulty engaging with social or other activities	Specification of context (e.g., self-blame, avoidance of places, difficulty participating in social activities due to lost access or inability, resistance vs. inability to accept loss, etc.) Suggestions for features to be added or modified: – Somatic/physical symptoms (e.g., constant crying, sleep problems) – Dissociation/paralysis – Lethargy/lack of energy or thrive – Loss of faith in one's world view – Regret – Hate – Despair, emptiness, or meaninglessness – Wish to be reunited with the deceased – Inability to develop or maintain satisfying relationships	Too vague or lack of a context or subject or not easy to be understood (e.g., blame, denial, preoccupation, and part of self lost) Overlap among features (e.g., denial, blame, and anger) Some features should be translated freely rather than directly (e.g., part of self lost, acceptance, and numbness) Suggestions for features to be added or modified: – Somatic/physical symptoms – Being balled up or dissociation/paralysis – Break in socialization – Helpless – Anxiety – Depression
C. Time and impairment criterion	Extended for an abnormally long period beyond the expected social and cultural norms (e.g., at least 6 months or longer depending on cultural and contextual factors) Sufficiently severe to cause significant impairment in the person's functioning	Considered to best distinguish between clinical and (sub)clinical cases Functional impairment in daily activities such as taking care of children, cooking, doing chores Extend time criterion to >6 months Suggestions for features to be added or modified: – Drastic behavior change – Not falling back into a "rhythm" – Loss of control – "Stuck" in grief/no change in grief	Functional impairment is very important for a diagnosis Define functional impairment clearly or give examples Extend the time criterion to >6 months

chores) and to specify the number of accessory symptoms needed to qualify for a PGD diagnosis [34–36]. These recommendations were surprising given that ICD-11 criteria aim to establish short, easy-to-use, flexible working diagnostic guidelines to accommodate the clinical judgment of HP [5]. However, this typological approach, which does not provide strict requirements for the number of symptoms needed to qualify for a diagnosis, seems too relaxed for our sample of HP. Lastly, German-speaking and Chinese HP suggested the addition of missing criteria (e.g., somatic symptoms and loss of faith in one's world). Interestingly, many of these suggested features re-

flect dimensions of already existing PGD criteria (e.g., relationship difficulties and looking for the deceased). We believe that this speaks to a low specificity of current PGD criteria and reflects the wish of HP for more specific symptom descriptions and examples [27]. Furthermore, it shows that HP considered the accessory symptoms listed (i.e., reflecting emotional distress) as exhaustive rather than examples of emotional distress. Reminders or instructions that other (related) symptoms can fall into this category of emotional distress will likely circumvent this problem.

When considering the responses of German-speaking and Chinese HP there were some detectable differences in the overall responses. It emerged that on general themes of the merits and acceptance of the ICD-11 criteria they had similar perspectives such as the importance for communication and the usability in the clinic. However, when considering the demerits, Chinese and German HP differed. Overall, German HP had more concerns regarding the pathologizing of grief and the validity of the diagnosis, whereas Chinese HP had specific concerns regarding the content of the ICD criteria and their cultural applicability. This reflects the tendency for criteria and guidelines from the Global North to be imposed upon other cultural groups [37]. Chinese HP clearly expressed the need for the consideration of cultural factors and specific symptoms when assessing disordered grief and this attests to the importance of bridging potential gaps in culturally specific assessment [38].

Implications for Practice

The present study has a number of implications for clinical practice. Specific criterion-related suggestions that emerged from this study are presented in Table 2. For example, HP suggested specification of criteria by inclusion of a more detailed description (e.g., change of preoccupation to preoccupation with the deceased or the circumstances of death) and by addition of examples (e.g., for the functionality criterion).

Given HP concerns regarding missing criteria and misdiagnosis, HP may also benefit from specific reminders or instructions when assigning a diagnosis according to ICD-11 guidelines. Such reminders should address that accessory symptoms represent only examples of emotional distress and are not exhaustive. Furthermore, HP should be reminded to focus on the time and functionality criterion due to the phenomenological overlap in normal and prolonged grief symptoms.

In considering global applicability, our participants strongly supported this cultural caveat while advising caution with its implementation for diagnosis. To overcome practical difficulties associated with culturally sensitive decision making, we encourage HP to take the time to explore existing sociocultural norms and beliefs together with their patients. One promising clinical assessment tool designed to enhance culturally sensitive decision making comprises the Cultural Formulation Interview (CFI) [37, 39]. To account for cultural aspects related to the death of a loved one, researchers have recently proposed a grief and bereavement supplement to the CFI [38].

Limitations and Future Directions

This is the first study to explore in depth the views of HP on the finalized ICD-11 PGD criteria via semistructured interviews and to provide specific recommendations and clinical implications for ICD-11 PGD criteria use which extends the existing research [6, 7]. In addition, this is the first study to contrast the perspectives of Chinese- and German-speaking HP. Despite its novelty, we acknowledge that our sample consisted predominantly of HP specializing in mental health with a bias towards and expertise in the study's subject matter, and thus we cannot draw any conclusions regarding general practitioners. Previous research suggests that physicians support the inclusion of PGD more strongly than HP specializing in mental health [7]. Furthermore, our sample did not include bereaved individuals or lay people in general even though it is plausible that non-HP may differ in their views on PGD. Future research should investigate differences in how different professions and the lay public assess the newly proposed criteria.

Conclusions

The present study explored and contrasted how well the newly proposed ICD-11 PGD criteria meet standards for clinical utility and international applicability among 24 Chinese and German-speaking HP. We found evidence for clinical utility and international applicability. Extending the previous literature, merits included improved clinical decision making, research promotion, and social acknowledgment. Main concerns included misdiagnosis, pathologizing, and a lack of specificity of criteria. Both Chinese and German-speaking HP emphasized the importance of global applicability. Differences between Chinese and German-speaking HP per-

tained predominantly to feature-specific, culture-specific modifications and extensions of the current criteria to overcome barriers of implementation. Specific recommendations for the use of ICD-11 criteria by HP and suggestions for research can be used to improve clinical practice.

Acknowledgment

We thank the interns Lorena Blocher, Beiwei Chen, Kim Haller, Marina Renner-Oertig, Niovi Stoupi, Jill Schell, and Kadir Turgut, who supported the collection of data and transcription and inter-rater coding of the qualitative data.

Statement of Ethics

Ethical approval was provided by the Faculty of Arts and Sciences Research Ethics Committee of the University of Zurich.

Disclosure Statement

There is no conflict of interests for any of the authors.

Funding Sources

This study received no specific grant from any funding agency in the public, commercial, or nonprofit sector.

References

1 Reed GM, First MB, Kogan CS, Hyman SE, Gureje O, Gaebel W, et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. World Psychiatry. 2019 Feb;18(1):3–19.
2 Maercker A, Brewin CR, Bryant RA, Cloitre M, Reed GM, van Ommeren M, et al. Proposals for mental disorders specifically associated with stress in the International Classification of Diseases-11. Lancet. 2013 May;381(9878):1683–5.
3 World Health Organization. ICD-11: mortality and morbidity statistics [Internet]. 2018. Available from: https://icd.who.int/browse11/l-m/en.
4 Keeley JW, Reed GM, Roberts MC, Evans SC, Medina-Mora ME, Robles R, et al. Developing a science of clinical utility in diagnostic classification systems field study strategies for ICD-11 mental and behavioral disorders. Am Psychol. 2016 Jan;71(1):3–16.
5 Killikelly C, Maercker A. Prolonged grief disorder for ICD-11: the primacy of clinical utility and international applicability. Eur J Psychotraumatol. 2017;8:1476441.
6 Odgen SP, Simmonds JG. Psychologists' and counsellors' perspectives on prolonged grief disorder and its inclusion in diagnostic manuals. Couns Psychother Res. 2014;14(3):212–9.
7 Dietl L, Wagner B, Fydrich T. User acceptability of the diagnosis of prolonged grief disorder: how do professionals think about inclusion in ICD-11? J Affect Disord. 2018 Mar;229:306–13.
8 Rüsch N, Evans-Lacko S, Thornicroft G. What is a mental illness? Public views and their effects on attitudes and disclosure. Aust N Z J Psychiatry. 2012 Jul;46(7):641–50.
9 Breen LJ, Penman EL, Prigerson HG, Hewitt LY. Can grief be a mental disorder? An exploration of public opinion. J Nerv Ment Dis. 2015 Aug;203(8):569–73.
10 Tang S, Chow AY, Breen LJ, Prigerson HG. Can grief be a mental disorder? An online survey on public opinion in mainland China. Death Stud. 2020;44(3):152–9.
11 Doering BK, Eisma MC. Treatment for complicated grief: state of the science and ways forward. Curr Opin Psychiatry. 2016 Sep;29(5):286–91.
12 Johnson JG, First MB, Block S, Vanderwerker LC, Zivin K, Zhang B, et al. Stigmatization and receptivity to mental health services among recently bereaved adults. Death Stud. 2009 Sep;33(8):691–711.
13 Wakefield JC. Should prolonged grief be reclassified as a mental disorder in DSM-5?: reconsidering the empirical and conceptual arguments for complicated grief disorder. J Nerv Ment Dis. 2012 Jun;200(6):499–511.
14 Keeley JW, Reed GM, Roberts MC, Evans SC, Robles R, Matsumoto C, et al. Disorders specifically associated with stress: A case-controlled field study for ICD-11 mental and behavioural disorders. Int J Clin Health Psychol. 2016 May-Aug;16(2):109–27.
15 Britten N. Qualitative interviews in medical research. BMJ. 1995 Jul;311(6999):251–3.
16 Kvale S, Brinkmann S. Interviews: Learning the craft of qualitative interviewing. London: Sage; 2009.
17 Marshall MN. Sampling for qualitative research. Fam Pract. 1996 Dec;13(6):522–5.
18 Creswell JW. Qualitative inquiry and research design: Choosing among five approaches. Thousand Oaks: SAGE; 2007.
19 Krishna K. Conducting key informant interviews. Washington: USAID; 1996.
20 Applied Mental Health Research (AMHR) Group. Design, Implementation, Monitoring and Evaluation (DIME). Baltimore: Johns Hopkins Bloomberg School of Public Health; 2013.
21 Ritchie J, Spencer L, Bryman A, Burgess RG. Analysing qualitative data. London: Routledge; 1994.
22 Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Med Res Methodol. 2013 Sep;13(1):117.
23 Pope C, Mays N, Ziebland S, le May A, Williams S, Coombs M, et al. Qualitative methods in health research. Methods. 2000;1:2.
24 Ghesquiere A, Thomas J, Bruce ML. Utilization of Hospice Bereavement Support by At-Risk Family Members. Am J Hosp Palliat Care. 2016 Mar;33(2):124–9.
25 Dodd A, Guerin S, Delaney S, Dodd P. Complicated grief: Knowledge, attitudes, skills and training of mental health professionals: A systematic review. Patient Educ Couns. 2017 Aug;100(8):1447–58.
26 Guldin MB, Vedsted P, Jensen AB, Olesen F, Zachariae R. Bereavement care in general practice: a cluster-randomized clinical trial. Fam Pract. 2013 Apr;30(2):134–41.
27 Boelen PA, Lenferink LI, Nickerson A, Smid GE. Evaluation of the factor structure, prevalence, and validity of disturbed grief in DSM-5 and ICD-11. J Affect Disord. 2018 Nov;240:79–87.
28 Eisma MC. Public stigma of prolonged grief disorder: an experimental study. Psychiatry Res. 2018 Mar;261:173–7.
29 Xu X, Li XM, Zhang J, Wang W. Mental health-related stigma in China. Issues Ment Health Nurs. 2018 Feb;39(2):126–34.
30 He L, Tang S, Yu W, Xu W, Xie Q, Wang J. The prevalence, comorbidity and risks of prolonged grief disorder among bereaved Chinese adults. Psychiatry Res. 2014 Oct;219(2):347–52.
31 Shi G, Wen J, Xu X, Zhou N, Wang J, Shi Y, et al. Culture-related grief beliefs of Chinese Shidu parents: development and psychometric properties of a new scale. Eur J Psychotraumatol. 2019 Jun;10(1):1626075.

32 Lam CS, Angell B, Tsang HW, Shi K, Corrigan PW, Jin S, et al. Chinese lay theory and mental illness stigma: implications for research and practices. J Rehabil. 2010;76:35–40.
33 Xu J. Death and dying in the Chinese culture: implications for health care practice. Home Health Care Manage Pract. 2007;19(5):412–4.
34 Boelen PA, Lenferink LI, Smid GE. Further evaluation of the factor structure, prevalence, and concurrent validity of DSM-5 criteria for Persistent Complex Bereavement Disorder and ICD-11 criteria for Prolonged Grief Disorder. Psychiatry Res. 2019 Mar;273:206–10.
35 Bonanno GA, Malgaroli M. Trajectories of grief: comparing symptoms from the DSM-5 and ICD-11 diagnoses. Depress Anxiety. 2020 Jan;37(1):17–25.
36 Cozza SJ, Shear MK, Reynolds CF 3rd, Fisher JE, Zhou J, Maercker A, et al. Optimizing the clinical utility of four proposed criteria for a persistent and impairing grief disorder by emphasizing core, rather than associated symptoms. Psychol Med. 2019 Mar:1–8.
37 Lewis-Fernández R, Aggarwal NK, Lam PC, Galfalvy H, Weiss MG, Kirmayer LJ, et al. Feasibility, acceptability and clinical utility of the Cultural Formulation Interview: mixed-methods results from the DSM-5 international field trial. Br J Psychiatry. 2017 Apr;210(4):290–7.
38 Smid GE, Groen S, de la Rie SM, Kooper S, Boelen PA. Toward Cultural Assessment of Grief and Grief-Related Psychopathology. Psychiatr Serv. 2018 Oct;69(10):1050–2.
39 Lewis-Fernández R, Aggarwal NK, Bäärnhielm S, Rohlof H, Kirmayer LJ, Weiss MG, et al. Culture and psychiatric evaluation: operationalizing cultural formulation for DSM-5. Psychiatry. 2014;77(2):130–54.